110TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
110–898

COMMUNITY PHARMACY FAIRNESS ACT OF 2007

SEPTEMBER 28, 2008.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. CONYERS, from the Committee on the Judiciary, submitted the following

REPORT

[To accompany H.R. 971]

[Including cost estimate of the Congressional Budget Office]

The Committee on the Judiciary, to whom was referred the bill (H.R. 971) to ensure and foster continued patient safety and quality of care by making the antitrust laws apply to negotiations between groups of independent pharmacies and health plans and health insurance issuers (including health plans under parts C and D of the Medicare Program) in the same manner as such laws apply to protected activities under the National Labor Relations Act, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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THE AMENDMENT

The amendment is as follows:

69–006

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Community Pharmacy Fairness Act of 2007".

SEC. 2. APPLICATION OF THE ANTITRUST LAWS TO INDEPENDENT PHARMACIES NEGOTIATING WITH HEALTH PLANS.

(a) IN GENERAL.—Any independent pharmacies who are engaged in negotiations with a health plan regarding the terms of any contract under which the pharmacies provide health care items or services for which benefits are provided under such plan shall, in connection with such negotiations, be entitled to the same treatment under the antitrust laws as the treatment to which bargaining units which are recognized under the National Labor Relations Act are entitled in connection with activities described in section 7 of such Act. Such a pharmacy shall, only in connection with such negotiations, be treated as an employee engaged in concerted activities and shall not be regarded as having the status of an employer, independent contractor, managerial employee, or supervisor.

(b) PROTECTION FOR GOOD FAITH ACTIONS.—Actions taken in good faith reliance on subsection (a) shall not be the subject under the antitrust laws of criminal sanctions nor of any civil damages, fees, or penalties beyond actual damages incurred.

(c) NO CHANGE IN NATIONAL LABOR RELATIONS ACT.—This section applies only to independent pharmacies excluded from the National Labor Relations Act. Nothing in this section shall be construed as changing or amending any provision of the National Labor Relations Act, or as affecting the status of any group of persons under that Act.

(d) EFFECTIVE DATE.—The exemption provided in subsection (a) shall apply to conduct occurring beginning on the date of the enactment of this Act.

(e) LIMITATIONS ON EXEMPTION.—Nothing in this section shall exempt from the application of the antitrust laws any agreement or otherwise unlawful conspiracy that—

(1) would have the effect of boycotting any independent pharmacy or group of independent pharmacies, or would exclude, limit the participation or reimbursement of, or otherwise limit the scope of services to be provided by, any independent pharmacy or group of independent pharmacies with respect to the performance of services that are within the scope of practice as defined or permitted by relevant law or regulation;

(2) allocates a market among competitors;

(3) unlawfully ties the sale or purchase of one product or service to the sale or purchase of another product or service; or

(4) monopolizes or attempts to monopolize a market.

(f) LIMITATION BASED ON MARKET SHARE OF GROUP.—This section shall not apply with respect to the negotiations of any group of independent pharmacies with a health plan regarding the terms of any contract under which such pharmacies provide health care items or services for which benefits are provided under such plan in a PDP region (as defined in subsection (j)(4)) if the number of pharmacy licenses of such pharmacies within such group in such region exceeds 25 percent of the total number of pharmacy licenses issued to all retail pharmacies (including both independent and other pharmacies) in such region.

(g) NO EFFECT ON TITLE VI OF CIVIL RIGHTS ACT OF 1964.—Nothing in this section shall be construed to affect the application of title VI of the Civil Rights Act of 1964.

(h) NO APPLICATION TO SPECIFIED FEDERAL PROGRAMS.—Nothing in this section shall apply to negotiations between independent pharmacies and health plans pertaining to benefits provided under any of the following:

(1) The Medicaid Program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) The State Children's Health Insurance Program (SHIP) under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(3) Chapter 55 of title 10, United States Code (relating to medical and dental care for members of the uniformed services).

(4) Chapter 17 of title 38, United States Code (relating to Veterans' medical care).

(5) Chapter 89 of title 5, United States Code (relating to the Federal employees' health benefits program).

(6) The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(i) DEFINITIONS.—For purposes of this section:

(1) ANTITRUST LAWS.—The term "antitrust laws"—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of

the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section 5 applies to unfair methods of competition; and

(B) includes any State law similar to the laws referred to in subparagraph (A).

(2) HEALTH PLAN AND RELATED TERMS.—

(A) IN GENERAL.—The term "health plan"—

(i) means a group health plan or a health insurance issuer that is offering health insurance coverage;

(ii) includes any entity that contracts with such a plan or issuer for the administering of services under the plan or coverage; and

(iii) includes a prescription drug plan offered under part D of title XVIII of the Social Security Act and a Medicare Advantage plan offered under part C of such title.

(B) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—The terms "health insurance coverage" and "health insurance issuer" have the meanings given such terms under paragraphs (1) and (2), respectively, of section 733(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(b)).

(C) GROUP HEALTH PLAN.—The term "group health plan" has the meaning given that term in section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1)).

(3) INDEPENDENT PHARMACY.—The term "independent pharmacy" means a pharmacy that has a market share of—

(A) less than 10 percent in any PDP region; and

(B) less than 1 percent in the United States.

For purposes of the preceding sentence, all pharmacies that are members of the same controlled group of corporations (within the meaning of section 267(f) of the Internal Revenue Code of 1986) and all pharmacies under common control (within the meaning of section 52(b) of such Code but determined by treating an interest of more than 50 percent as a controlling interest) shall be treated as 1 pharmacy.

(4) PDP REGION.—The term "PDP region" has the meaning given such term in section 1860D-11(a)(2) of the Social Security Act (42 U.S.C. 1395w-111(a)(2)).

(j) 5-YEAR SUNSET.—The exemption provided in subsection (a) shall only apply to conduct occurring during the 5-year period beginning on the date of the enactment of this Act and shall continue to apply for 1 year after the end of such period to contracts entered into before the end of such period.

(k) GENERAL ACCOUNTING OFFICE STUDY AND REPORT.—The Comptroller General of the United States shall conduct a study on the impact of enactment of this section during the 6-month period beginning with the 5th year of the 5-year period described in subsection (j). Not later than the end of such 6-month period, the Comptroller General shall submit to Congress a report on such study and shall include in the report such recommendations on the extension of this section (and changes that should be made in making such extension) as the Comptroller General deems appropriate.

(l) OVERSIGHT.—Nothing in this section shall preclude the Federal Trade Commission or the Department of Justice from overseeing the conduct of independent pharmacies covered under this section.

PURPOSE AND SUMMARY

H.R. 971 allows independent pharmacists to negotiate collectively on the terms and conditions of their reimbursement from Pharmacy Benefit Managers (PBMs). It does this by granting groups of pharmacists a waiver from Federal antitrust laws and treats them as employees, able to bargain collectively, under the National Labor Relations Act. This exemption will allow small pharmacies to compete with large retail pharmacies, and will allow them to negotiate better reimbursement rates and terms.

BACKGROUND AND NEED FOR THE LEGISLATION

Pharmaceutical care is one of the most important parts of the entire health care system. Pharmacies serve as the interface between consumers and their medications. Independent pharmacies provide necessary and important services to patients all over the country,

but they are struggling to find ways to compete and make a profit in today's marketplace.

Independent pharmacies report that they cannot compete effectively with massive pharmacy chains. While the chains can negotiate profitable reimbursement rates with Pharmacy Benefit Managers (PBMs) for prescription drugs, the independent pharmacies have no leverage over the PBMs and are often left with "take-it-or-leave-it" offers. They also report that the lag-time between dispensing the drug and receiving the payment can upend their business' fiscal solvency. The pharmacies must make difficult financial decisions in order to remain open, sometimes taking on debt or limiting their services. In communities dominated by particular insurers (if, for example, more than half of a pharmacy's patrons have insurance through their work at a local factory), the independent pharmacies can have little choice but to accept the PBMs' negotiated payment offers without question.

This legislation will allow independent pharmacies to collectively bargain so that they can negotiate with the insurance companies on the reimbursement rates and terms. H.R. 971 allows pharmacies negotiating contracts with health insurers to receive the same treatment under the antitrust laws as bargaining units recognized under the National Labor Relations Act (NLRA). This would permit pharmacies to be considered employees under the NLRA for purposes of the Act and not subject to treble damages under the antitrust laws. The Act defines independent pharmacies as those that are neither owned nor operated by a publically traded company.[1]

How the system works

Pharmacies purchase their pharmaceutical products from drug wholesalers and manufacturers. The pharmacies purchase the pharmaceutical at a price known as the wholesale acquisition cost (or WAC). The pharmacy sells the medication to consumers, and when the consumer is the beneficiary of a prescription drug plan, the pharmacy receives funds from the consumer in the form of a co-payment, and from a Pharmacy Benefit Manager (PBM) in the form of a reimbursement. The reimbursement price, or the "negotiated payment," constitutes the drug's average wholesale price (or AWP) less the discount that the PBM will offer on the particular drug (and plus, usually, an administrative fee for the process). A PBM might reimburse a pharmacy with a rate, for example, of negotiated payment = [AWP – 15%] + $2. This transaction, however, can become protracted over several months as funds flow from the health insurer (be it the Federal Government or a private insurance company) to the PBM and then to the pharmacy.

What are Pharmacy Benefit Managers?

Pharmacy Benefit Managers (PBMs) are the middlemen that administer the prescription drug benefit portion of health insurance plans for private companies, unions, and governments. PBMs are responsible for processing and paying prescription drug claims, for developing formularies,[2] contracting with pharmacies, and negoti-

[1] Duane Reade, Inc provides one well-known example of such a pharmacy.

[2] Formularies are drug lists that PBMs develop and use to manage drug spending. By charging less for certain brands of drugs, PBM formularies steer health care consumers and their physicians into using particular drugs for particular therapeutic needs. The consumer pays a

ating discounts and rebates with drug manufacturers.[3] PBMs manage 95% of all prescriptions sold in the United States.

PBMs operate on different business models. Most implement "spread pricing," where PBMs execute contracts with their clients (employers) that allow the PBMs to purchase drugs at lower prices but to invoice the clients at higher prices, thus profiting from a "spread" in the pricing. Another business model is the "pass through" model, where PBMs execute contracts that require the PBMs to pass through to the clients the precise purchase or reimbursement cost. In this situation, PBMs generate profits by charging a flat, per claim or per member, administrative fee.

Concerns about PBM Business Practices

PBMs do not sell drugs directly to pharmacies, but their monolithic role in negotiating with HMOs (Health Maintenance Organizations), employers, unions, preferred providers, pharmaceutical companies, and their own mail-order companies has raised several questions about the transparency and openness of the pharmaceutical marketplace. PBMs also operate mail-order pharmacies, and due to the companies' involvement in price and formulary negotiations, concerns have also arisen over drug-price inflation and anti-competitive drug distribution schemes.

Several calculations and actors come into play in valuing a pharmaceutical product's average wholesale price, or AWP, as the amount is set by both the drug manufacturer/labeler and wholesalers. Because the AWP is neither standard nor immune to market fluctuations, drug pricing becomes vulnerable to potential manipulation on several fronts by the PBMs. One possible source for manipulation comes from their mail-order pharmacies, as PBMs can effect the market value of a drug when they become involved in the marketing of drugs. Through the course of their mail-order operations, PBMs can obtain "repackager" licensing from the Food and Drug Administration. Repackaging licenses allow an entity to repackage drugs (when a licensee purchases10,000 tablets from a manufacturer, for example, they can redistribute the order among 50-tablet bottles), and the repackaged product's price will contribute to the drug's overall AWP. If a PBM artifically inflates an AWP through its repackaging and pricing practices, it can then increase its market share by offering artificially large discounts on the inflated drug price.

The PBMs can further increase their market share by compelling consumers to use their mail-order service by way of their relationships with managed care providers. In negotiating their contracts, PBMs can develop co-pay plans with insurers under which consumers pay a lower co-pay for prescriptions when they use the PBMs' mail-order services versus filling prescriptions at a community pharmacy.

In addition to unease over PBMs' alleged mail-order and price-bargaining practices, significant concerns have surfaced over PBMs' role in the management of drug formularies. Formularies, in es-

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higher co-pay (and the health plan pays the PBM more) for drugs that are not in the "preferred" category on the PBM's formulary. The health plan may provide no coverage for drugs that are not on the list.

[3] Because of their large purchasing pool for prescription drugs, PBMs can negotiate rebates and discounts on behalf of their clients.

sence, consist of lists that outline and set drug spending patterns. When a PBM develops its formulary—or its "menu" of drug prices—and charges less for a particular product, the PBM naturally guides consumers and physicians to purchase particular products. The health plan managing the prescription benefit, in turn, uses its PBM's formulary to create "preferred" lists of drug therapies, and can levy higher co-pays on or deny coverage to consumers for drugs that to do not appear on these lists.

It is argued that control over formularies endows PBMs with considerable influence over pharmaceutical companies. Drug manufacturers seek to secure favorable placements on the PBMs' formularies, for a favorable placement can determine a product's commercial success. Manufacturers compete with each other through a combination of rebates and administrative fee structures.

Need for the Legislation

Supporters of H.R. 971 expect that allowing pharmacists to bargain collectively will enable the newly formed alliances to more equitably compete with national chains and mail-order pharmacies. Because the purchase power of an independent community pharmacy pales in comparison to that of a chain pharmacy, the independent community pharmacies are often forced to accept the rates that a PBM offers, with no negotiation. If, for example, over half of a pharmacy's patrons have their prescription coverage administered by one PBM, the pharmacy is left with little choice but to accept the contract that the PBM offers.

With an antitrust exemption to negotiate collectively, independent pharmacies could pool their combined purchasing power to negotiate lower drug purchasing plans with the PBMs. Because PBMs would broker with a wider range of pharmacies, the marketplace would become more competitive and pro-consumer.

Independent pharmacists believe their situation is quite different from a normal competitive marketplace: here, small independent businesses must compete directly with much larger companies at the retail level, with all retailers reimbursed by a few large middlemen instead of the consumer.

Of further concern is that one of the largest retail competitors (CVS) also owns one of the largest PBMs (Caremark). The vertical nature of this arrangement within the market creates concern at several layers of the industry. There is great concern that a single, dominant corporation has an exclusive role in determining a drug formulary, the AWP for those drugs in the greater market, and the delivery of those drugs to consumers.

Hearings

The Committee on the Judiciary, Antitrust Task Force held one hearing on the "Impact of Our Antitrust Laws on Community Pharmacies and Their Patients" on October 18, 2007. Testimony was received from Mr. Mike James, President, Association of Community Pharmacies Congressional Network, and Pharmacist and Owner, Person Street Pharmacy, Raleigh, NC; Dr. Peter J. Rankin, Principal, CRA International; Mr. David Wales, Deputy Director, Bureau of Competition, Federal Trade Commission; Mr. David Balto, on behalf of the National Community Pharmacists Association; and

Mr. Robert Dozier, Executive Director, Mississippi Independent Pharmacies Association.

Committee Consideration

On November 7, 2007 Committee met in open session and ordered the bill H.R. 971 favorably reported with an amendment, by voice vote, a quorum being present.

Committee Votes

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the Committee advises that there were no recorded votes during the Committee's consideration of H.R. 971.

Committee Oversight Findings

In compliance with clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee advises that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated in the descriptive portions of this report.

New Budget Authority and Tax Expenditures

Clause 3(c)(2) of rule XIII of the Rules of the House of Representatives is inapplicable because this legislation does not provide new budgetary authority or increased tax expenditures.

Congressional Budget Office Cost Estimate

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the Committee sets forth, with respect to the bill, H.R. 971, the following estimate and comparison prepared by the Director of the Congressional Budget Office under section 402 of the Congressional Budget Act of 1974:

U.S. Congress,
Congressional Budget Office,
Washington, DC, September 26, 2008.

Hon. John Conyers, Jr., *Chairman,*
Committee on the Judiciary,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 971, the Community Pharmacy Fairness Act of 2007. This estimate updates and supersedes a previous CBO cost estimate transmitted on January 11, 2008. The updated estimate reflects changes in baseline projections (underlying the current budget resolution), and results in an estimated 10-year deficit impact that is $87 million lower than estimated under CBO's previous baseline.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Andrea Noda, who can be reached at 226–9010.

Sincerely,

PETER R. ORSZAG,
DIRECTOR.

Enclosure

cc: Honorable Lamar S. Smith.
Ranking Member

H.R. 971—Community Pharmacy Fairness Act of 2007.

SUMMARY

H.R. 971 would create an exemption to antitrust laws for five years to permit independent pharmacies to negotiate collectively with health plans and issuers of health insurance over payment rates and other contract terms. That exemption would apply to negotiations between independent pharmacies and operators of prescription drug plans offered under part D of Medicare. However, the exemption would not apply to most other Federal health insurance programs.

Enacting the bill would affect Federal revenues and direct spending for Medicare Part D, Medicaid, and the Federal Employees Health Benefits (FEHB) program, beginning in 2009. CBO estimates that enacting the bill would reduce Federal tax revenues by $105 million over the 2008–2013 period and by $120 million over the 2008–2018 period. Social Security payroll taxes, which are off-budget, would account for about a third of those totals.

CBO estimates that enacting the bill would increase Federal direct spending for health benefits by $488 million over the 2008–2013 period and by $520 million over the 2008–2018 period. The combined effect of the estimated changes in revenues and direct spending would reduce surpluses or increase deficits by $640 million over the 2008–2018 period.

In addition, CBO estimates that enacting the bill would increase discretionary spending by Federal agencies for FEHB premiums for current employees by $9 million over the 2009–2013 period, assuming appropriation of the necessary amounts.

H.R. 971 contains an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) because it would preempt State antitrust laws. CBO estimates that because the preemption would only limit the application of State law, the mandate would impose no costs on State, local, or tribal governments.

As a result of this legislation, some State, local, and tribal governments would incur higher expenses as purchasers of health care for their employees and as providers of health care under Medicaid. However, those costs would not result from intergovernmental mandates.

This bill contains no private-sector mandates as defined by UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 971 is shown in the following table. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

BASIS OF ESTIMATE

H.R. 971 would allow independent pharmacies to negotiate collectively with health plans and issuers of health insurance over payment rates and other contract terms. Under the bill, such negotiations would be entitled to the same treatment under the antitrust laws as the treatment to which bargaining units that are recognized under the National Labor Relations Act are entitled. To qualify for the exemption, the pharmacies participating in a collective negotiation could not constitute more than 1 percent of the U.S. market or 10 percent of the market in a region (as defined by the Medicare Part D program). That exemption from the antitrust laws, however, would not apply to negotiations between independent pharmacies and health plans pertaining to most Federal health insurance benefits, with the exception of prescription drug plans offered under part D of Medicare. The exemption from antitrust law for independent pharmacies would be effective for five years beginning on the date of the enactment of this bill.

ESTIMATED BUDGETARY EFFECTS OF H.R. 971

	By Fiscal Year, in Millions of Dollars												
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2008–2013	2008–2018
CHANGES IN REVENUES													
Income and HI Payroll Taxes (on-budget)	0	–5	–10	–15	–20	–20	–10	0	0	0	0	–70	–80
Social Security Payroll Taxes (off-budget)	0	0	–5	–10	–10	–10	–5	0	0	0	0	–35	–40
Total Changes	0	–5	–15	–25	–30	–30	–15	0	0	0	0	–105	–120
CHANGES IN DIRECT SPENDING													
Medicare.													
Estimated Budget Authority	0	20	70	120	110	140	30	0	0	0	0	460	490
Estimated Outlays	0	20	70	120	110	140	30	0	0	0	0	460	490
Other Federal Programs.													
Estimated Budget Authority	0	1	4	7	8	9	2	0	0	0	0	28	30
Estimated Outlays	0	1	4	7	8	9	2	0	0	0	0	28	30
Total Changes.													
Estimated Budget Authority	0	21	74	127	118	149	32	0	0	0	0	488	520
Estimated Outlays	0	21	74	127	118	149	32	0	0	0	0	488	520

ESTIMATED BUDGETARY EFFECTS OF H.R. 971—Continued

	By Fiscal Year, in Millions of Dollars												
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2008–2013	2008–2018
NET IMPACT ON THE FEDERAL BUDGET													
Estimated Increase in Deficits or Decrease in Surpluses	0	26	89	152	148	179	47	0	0	0	0	593	640

Notes: HI = Hospital Insurance (Part A of Medicare).

Implementing H.R. 971 would increase discretionary spending by Federal agencies for health insurance premiums for current employees enrolled in the Federal Employees Health Benefits program by an estimated $9 million over the 2009–2013 and $17 million over the 2009–2018 periods, assuming appropriation of the necessary amounts.

REVENUES

CBO estimates that H.R. 971, if enacted, would increase payments for prescription drugs distributed by independent pharmacies by about 1 percent in 2010, when the majority of the contracts affected by the policy would have been renegotiated. CBO's estimate is based in part on data gathered through interviews with industry experts and representatives of the pharmacy and health plan industries. CBO's analysis took into account both the market shares of independent pharmacies and the desire of health plans to establish an attractive network of retail pharmacies or to meet adequacy-of-network requirements. CBO also took into account the duration of typical contracts in estimating the effects of the bill.

The increased cost to plans for prescription drugs would increase premiums for group health insurance by less than 0.1 percent in 2010, before accounting for the responses of health plans, employers, and workers to the higher premiums that would likely be charged under the bill. Those responses would include reductions in the scope or generosity of health insurance benefits, such as increased deductibles or higher copayments. CBO expects that those behavioral responses would offset 60 percent of the potential impact of the bill on the total costs of health plans.

The remaining 40 percent of the potential increase in costs would occur in the form of higher spending for health insurance. Those costs would be passed through to workers, reducing both their taxable compensation and other fringe benefits. For employees of private firms, CBO assumed that all of that increase would ultimately be passed through to workers. The estimate assumes that State, local, and tribal governments would absorb 75 percent of the increase and that changes in their workers' taxable income and other fringe benefits would offset the remaining one-quarter of the increase.

Those reductions in workers' taxable compensation would lead to lower Federal tax revenues. CBO estimates that Federal tax revenues would fall by $5 million in 2009 and by $120 million over the 2008–2018 period if H.R. 971 were enacted. Social Security payroll taxes, which are off-budget, would account for about one-third of those totals.

Direct Spending

H.R. 971 would affect negotiations between independent pharmacies and health plans that provide prescription drug benefits under Part D of Medicare. CBO estimates that the bill, if enacted, would increase payments for prescription drugs distributed by independent pharmacies by about 1 percent by 2010, and would therefore increase Federal direct spending for Part D of Medicare by $460 million over the 2008–2013 period and by $490 million over the 2008–2018 period.

The bill would maintain antitrust liability for independent pharmacies in negotiations with health plans that provide prescription drug benefits for certain other Federal health programs, such as Medicaid and the FEHB program. However, to take advantage of that limitation on the ability of independent pharmacies to bargain collectively, health plans would have to conduct separate negotiations for their Medicaid or FEHB populations and for their commercial business. CBO anticipates that some plans would choose not to conduct such separate negotiations because that could reduce their leverage for obtaining discounts. CBO expects that the effect on Medicaid and FEHB of enacting H.R. 971 would be about one-quarter of the effect in the private sector. As a result, CBO estimates that enacting H.R. 971 would increase Federal spending for Medicaid and the FEHB program by $28 million over the 2008–2013 period and $30 million over the 2008–2018 period.[1]

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

Intergovernmental Mandates

H.R. 971 contains an intergovernmental mandate, but CBO estimates that the mandate would impose no costs on State, local, or tribal governments. By exempting certain pharmacies from State antitrust laws, the bill would preempt State law, and that preemption would be a mandate as defined in UMRA. However, the bill would not require States to take action as regulators in order to comply with the new exemption, and in some cases it might reduce their oversight responsibilities.

Other Impacts

With certain pharmacies exempted from antitrust laws, State, local, and tribal governments would experience an increase in premiums for health insurance for their employees. CBO estimates that those governments would face additional costs of about $20 million over the 2008–2013 period. This estimate reflects the assumption that governments would shift roughly 25 percent of the additional costs to their employees.

The bill would maintain antitrust liability for pharmacies that provide services for Federal health benefit programs, including Medicaid. However, those programs would not be completely shielded from the market changes precipitated by the bill. Consequently,

[1] Only the government's share of premiums for Federal retirees enrolled the FEHB program is classified as direct spending. CBO estimates that implementing H.R. 971 would also increase discretionary spending by Federal agencies for FEHB premium payments for current employees by $9 million over the 2009–2013 and $17 million over the 2009–2018 periods. (Federal spending for active workers participating in the FEHB program is included in the appropriations for Federal agencies, and therefore is discretionary.)

CBO estimates that State expenditures for Medicaid would increase by about $15 million over the 2008–2013 period.

H.R. 971 contains no private-sector mandates as defined by UMRA.

PREVIOUS CBO ESTIMATE

On January 11, 2008, CBO transmitted a cost estimate of H.R. 971 as ordered reported by the House Judiciary Committee on November 7, 2007. The legislative language has not changed. CBO's estimate has been updated to reflect the March 2008 baseline assumptions that underly the current budget resolution. Under the updated baseline, we estimate the net deficit impact of the bill would be $87 million lower over the 2008–2018 period than previously estimated. The decrease is a result of lower projected Part D spending over that period.

ESTIMATE PREPARED BY:

Federal Costs: Andrea Noda and Julia Christensen (226–9010)
Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum (225–3220)
Impact on the Private Sector: Anna Cook and Patrick Bernhardt (226–2666)

ESTIMATE APPROVED BY:

Peter H. Fontaine
Assistant Director for Budget Analysis

Performance Goals and Objectives

The Committee states that pursuant to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, H.R. 971 allow independent pharmacies to collectively negotiate terms and conditions of their PBM reimbursement.

Constitutional Authority Statement

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds the authority for this legislation in article I, section 8, clause 3 of the Constitution.

Advisory on Earmarks

In accordance with clause 9 of rule XXI of the Rules of the House of Representatives, H.R. 971 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(d), 9(e), or 9(f) of Rule XXI.

Section-by-Section Analysis

The following discussion describes the bill as reported by the Committee.

Sec. 1. Short title. Section 1 sets forth the short title of the bill as the "Community Pharmacy Fairness Act of 2007."

Sec. 2. Application of the Antitrust Laws to Independent Pharmacies Negotiating with Health Plans. Section 2(a) entitles independent pharmacies to the same antitrust law treatment as bargaining units recognized under Section 7 of the National Labor Re-

lations Act (NRLA). Independent pharmacies would have the right to act specifically as "an employee" under the NRLA. Section 2(b) guarantees that pharmacies acting in good faith reliance on subsection (a) would only be subject to actual damages and would not be subject to criminal sanctions. Section 2(c) specifies that this section does not affect any provision of the National Labor Relations Act or the status of any group of persons under that Act. Section 2(d) states that subsection (a) becomes effective on the date of enactment. Section 2(e) prohibits any other agreement or unlawful conspiracy that: (1) would have the effect of boycotting any independent pharmacy or group of pharmacies; (2) allocates a market among competitors; (3) unlawfully ties the sale or purchase of one product or service to the sale or purchase of another product or service; or (4) monopolizes or attempts to monopolize a market. Section 2(f) limits the negotiating groups to no more than 25% of the number of licensed, retail pharmacies within a Medicare Part D Prescription Drug Plan region. Section 2(g) states that this act does not affect the application of title VI of the Civil Rights Act of 1964. Section 2(h) states that the act does not apply to negotiations between independent pharmacies and health plans pertaining to benefits under various other Federal programs, such as Medicaid, SCHIP and others. Section 2(i) provides definitions for "antitrust laws," "health plan," "health insurance coverage," "health insurance issuer," "group health plan," "independent pharmacy," and "PDP region." Section 2(j) provides for a 5 year sunset of the antitrust exemption. Section 2(k) provides for a GAO study on the impact of enactment of this section during the 6 month period beginning with the 5th year of the 5 year period. The Comptroller General must provide a report to Congress on the study and include recommendations on the extension of this section. Section 2(l) states that this section does not preclude the FTC or DOJ from overseeing the conduct of independent pharmacies covered under this section.

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